

		FOR OFF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022871

Facility Name: WEST CHICAGO TERRACE

Address: 928 JOLIET ROAD WEST CHICAGO 60185
Number City Zip Code

County: DU PAGE

Telephone Number: (847) 674-5795 Fax # (847) 674-5794

IDPA ID Number: 36-2883297

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	MORRIS ESFORMES	
	(Title)	GENERAL PARTNER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585	Fax # (847) 675-5777
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number WEST CHICAGO TERRACE

0022871 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	38,107	3,298	222	41,627	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,107	3,298	222	41,627	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.04%

D. How many bed-hold days during this year were paid by Public Aid? 1,239 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 10/1/76

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **WEST CHICAGO TERRACE** # **0022871** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	133,854	8,720	6,345	148,919		148,919		148,919			1
2	Food Purchase		151,021		151,021		151,021	(727)	150,294			2
3	Housekeeping	84,438	15,124		99,562		99,562		99,562			3
4	Laundry	41,650	12,551	1,760	55,961		55,961		55,961			4
5	Heat and Other Utilities			106,190	106,190		106,190	343	106,533			5
6	Maintenance	91,985	12,024	25,431	129,440		129,440	(984)	128,456			6
7	Other (specify):*			7,869	7,869		7,869	22	7,891			7
8	TOTAL General Services	351,927	199,440	147,595	698,962		698,962	(1,346)	697,616			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	989,831	28,833	8,232	1,026,896		1,026,896		1,026,896			10
10a	Therapy	30,103		2,706	32,809		32,809		32,809			10a
11	Activities	63,519	3,817	1,571	68,907		68,907		68,907			11
12	Social Services	19,591		1,929	21,520		21,520		21,520			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,103,044	32,650	18,438	1,154,132		1,154,132		1,154,132			16
	C. General Administration											
17	Administrative	121,839		325,750	447,589		447,589	(300,866)	146,723			17
18	Directors Fees											18
19	Professional Services			42,265	42,265		42,265	5,565	47,830			19
20	Dues, Fees, Subscriptions & Promotions			12,447	12,447		12,447	(6,106)	6,341			20
21	Clerical & General Office Expenses	65,649	11,372	116,525	193,546		193,546	(82,813)	110,733			21
22	Employee Benefits & Payroll Taxes			207,465	207,465		207,465	(1,825)	205,640			22
23	Inservice Training & Education			780	780		780	22	802			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,675	9,675		9,675	434	10,109			25
26	Insurance-Prop.Liab.Malpractice			79,529	79,529		79,529	581	80,110			26
27	Other (specify):*							3,827	3,827			27
28	TOTAL General Administration	187,488	11,372	794,436	993,296		993,296	(381,181)	612,115			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,642,459	243,462	960,469	2,846,390		2,846,390	(382,527)	2,463,863			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	6,345
	REPAIRS & MAINTENANCE		0
			0
			6,345
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		1,760
			0
			1,760
5	HEAT & OTHER UTILITIES		
	GAS HEAT		41,806
	ELECTRICITY		27,181
	WATER		37,203
	CABLE TV - LOBBY		0
			0
			106,190
6	MAINTENANCE		
	GROUNDS MAINTENANCE		4,305
	PAINTING & DECORATING		4,134
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		9,720
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		1,102
	EXTERMINATING SERVICE		963
	FIRE SERVICE		5,207
			0
			0
			0
			25,431
7	OTHER		
	SCAVENGER		6,974
	SECURITY SERVICE		895
			7,869
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,000
			4,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	4,932
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	DENTAL		3,300
			0
			8,232
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B 47-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,050
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	656
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			2,706
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,571
			0
			1,571
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,929
	SOCIAL WORKER	XVIII B 45-2	0
			0
			1,929
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 325,750	325,750
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 11,549	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 30,716	
		0	42,265
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 4,058	
	EMPLOYEE WANT ADS	XIX F 794	
	CONTRIBUTIONS	VI 20 XIX F 500	
	DUES & SUBSCRIPTIONS	XIX F 3,998	
	LICENSES & PERMITS	XIX F 1,183	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 566	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 1,348	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	12,447
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	130	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	77,380	
	PENALTIES / OVERDRAFT CHARGES	VI 18 0	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	13,942	
	MESSENGER SERVICE	0	
	STAFF DEVELOPMENT	25,073	116,525

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 125,650	
	UNEMPLOYMENT COMPENSATION	XIX D 10,905	
	WORKERS COMPENSATION INSURANCE	XIX D 37,267	
	HOSPITALIZATION INSURANCE	XIX D 31,818	
	EMPLOYEE BENEFITS - OTHER	XIX D 0	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 1,825	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	207,465
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	780	780
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	9,675	9,675
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	79,529	79,529
27	OTHER		
	BAD DEBTS	VI 24 0	
		0	0

GRAND TOTAL COLUMN 3 OTHER

960,469

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			25,374	25,374		25,374	142	25,516			30
31	Amortization of Pre-Op. & Org.			2,494	2,494		2,494		2,494			31
32	Interest			31,349	31,349		31,349	1,247	32,596			32
33	Real Estate Taxes			82,833	82,833		82,833	1,768	84,601			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,524	26,524		26,524	3,259	29,783			35
36	Other (specify):* OFFICE RENT			9,360	9,360		9,360	(9,360)				36
37	TOTAL Ownership			177,934	177,934		177,934	(2,944)	174,990			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			65,700	65,700		65,700		65,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,642,459	243,462	1,204,103	3,090,024		3,090,024	(385,471)	2,704,553			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(942)	30		9
10	Interest and Other Investment Income	(175)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(727)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,848)	20		20
21	Owner or Key-Man Insurance	(1,825)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,058)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(566)	20		28
29	Other-Attach Schedule	(28,053)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,194)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(347,277)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (347,277)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (385,471)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (2,980)	6	1
2	STAFF DEVELOPMENT	(25,073)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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28				28
29				29
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(28,053)		49

Summary A

12/31/2003

[illegible]

Summary B

12/31/2003

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 314,000	EMI ENTERPRISES		\$	\$ (314,000)	1
2	V								2
3	V	17	OFFICERS SALARY				8,705	8,705	3
4	V	19	ACCOUNTING FEES				112	112	4
5	V	21	OFFICE EXPENSE				4,639	4,639	5
6	V	25	TRANSPORTATION				132	132	6
7	V	26	INSURANCE				104	104	7
8	V	27	EMPLOYEE BENEFITS				1,478	1,478	8
9	V	35	AUTO LEASE				645	645	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 314,000			\$ 15,815	\$ * (298,185)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING	\$ 77,380	EKS MANAGEMENT		\$	\$ (77,380)	15
16	V								16
17	V								17
18	V	6	PAINTING/DECORATING				1,448	1,448	18
19	V	7	SCAVENGER				22	22	19
20	V	17	CFO SALARY				4,429	4,429	20
21	V	19	PROFESSIONAL FEES				5,307	5,307	21
22	V	20	WANT ADDS/BACKGR CKS				366	366	22
23	V	21	OFFICE EXPENSE				14,932	14,932	23
24	V	23	SEMINARS				22	22	24
25	V	25	TRANSPORTATION				302	302	25
26	V	26	INSURANCE				408	408	26
27	V	27	EMPLOYEE BENEFITS				2,349	2,349	27
28	V	30	DEPRECIATION				162	162	28
29	V	35	EQUIPMENT RENT				2,528	2,528	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 77,380			\$ 32,275	\$ * (45,105)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	\$ 9,360	IME REALTY		\$	\$ (9,360)	15
16	V								16
17	V								17
18	V	5	UTILITIES				343	343	18
19	V	6	REPAIR & MAINTENANCE				548	548	19
20	V	19	PROFESSIONAL FEES				146	146	20
21	V	21	OFFICE EXPENSE				69	69	21
22	V	26	INSURANCE				69	69	22
23	V	30	DEPRECIATION				922	922	23
24	V	32	INTEREST				1,422	1,422	24
25	V	33	RE TAX				1,768	1,768	25
26	V	35	STORAGE FEES				86	86	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 9,360			\$ 5,373	\$ * (3,987)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD COHEN	GENERAL PARTN	ADMINISTRATION					MGMT FEE	\$ 11,750	17-3	1
2	MORRIS ESFORMES	GENERAL PARTN	ADMINISTRATION					SALARY	8,705	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	4,429	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 24,884		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Ending: 2/31/2003

(847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	17	OFFICERS SALARY	PATIENT DAYS	884,739	14	\$ 185,000	\$ 185,000	41,627	\$ 8,705	1
	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381		41,627	112	2
	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	98,637	76,255	41,627	4,639	3
	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845		41,627	132	4
	26	INSURANCE	PATIENT DAYS	884,739	14	2,209		41,627	104	5
	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442		41,627	1,478	6
	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730		41,627	645	7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$ 336,244	\$ 261,255		\$ 15,815	25

Facility Name & ID Number WEST CHICAGO TERRACE# 0022871 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

EKS MANAGEMENT

Street Address

6865 N LINCOLN AVE

City / State / Zip Code

LINCOLNWOOD, IL 60712

Phone Number

(847) 674-1946

Fax Number

(847) 674-1962

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	<u>PAINTING/DECORATING</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>\$ 30,769</u>	<u>\$ 30,769</u>	<u>41,627</u>	<u>\$ 1,448</u>	<u>1</u>
2	7	<u>SCAVENGER</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>510</u>		<u>41,627</u>	<u>22</u>	<u>2</u>
3	17	<u>CFO SALARY</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>94,128</u>	<u>94,128</u>	<u>41,627</u>	<u>4,429</u>	<u>3</u>
4	19	<u>PROFESSIONAL FEES</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>112,835</u>	<u>83,281</u>	<u>41,627</u>	<u>5,307</u>	<u>4</u>
5	20	<u>WANT ADDS/BACKGR CKS</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>7,759</u>		<u>41,627</u>	<u>366</u>	<u>5</u>
6	21	<u>OFFICE EXPENSE</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>317,364</u>	<u>228,335</u>	<u>41,627</u>	<u>14,932</u>	<u>6</u>
7	23	<u>SEMINARS</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>490</u>		<u>41,627</u>	<u>22</u>	<u>7</u>
8	25	<u>TRANSPORTATION</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>6,427</u>		<u>41,627</u>	<u>302</u>	<u>8</u>
9	26	<u>INSURANCE</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>8,715</u>		<u>41,627</u>	<u>408</u>	<u>9</u>
10	27	<u>EMPLOYEE BENEFITS</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>49,951</u>		<u>41,627</u>	<u>2,349</u>	<u>10</u>
11	30	<u>DEPRECIATION</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>3,418</u>		<u>41,627</u>	<u>162</u>	<u>11</u>
12	35	<u>EQUIPMENT RENT</u>	<u>PATIENT DAYS</u>	<u>884,739</u>	<u>14</u>	<u>53,700</u>		<u>41,627</u>	<u>2,528</u>	<u>12</u>
13										<u>13</u>
14										<u>14</u>
15										<u>15</u>
16										<u>16</u>
17										<u>17</u>
18										<u>18</u>
19										<u>19</u>
20										<u>20</u>
21										<u>21</u>
22										<u>22</u>
23										<u>23</u>
24										<u>24</u>
25	TOTALS					<u>\$ 686,066</u>	<u>\$ 436,513</u>		<u>\$ 32,275</u>	<u>25</u>

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	SOUTH TRUST		X	MORTGAGE		08/01/95	\$ 1,390,000	\$ 987,159	07/13/15		\$ 28,311	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	LASALLE BANK		X	WORKING CAPITAL							3,038	6	
7												7	
8	RELATED PARTY	X									1,422	8	
9	TOTAL Facility Related						\$ 1,390,000	\$ 987,159			\$ 32,771	9	
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES								10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,390,000	\$ 987,159			\$ 32,771	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.	\$	63,800		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	74,580		2
3. Under or (over) accrual (line 2 minus line 1).	\$	10,780		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	75,300		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 3,247 For 2002 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(3,247)		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	82,833		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	61,858	8	
	1999	60,602	9	
	2000	61,406	10	
	2001	63,216	11	
	2002	74,580	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.				
	FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2002	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

WEST CHICAGO TERRACE

COUNTY

DU PAGE

FACILITY IDPH LICENSE NUMBER

0022871

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 04-16-202-008	NURSING HOME	\$ 74,580.44	\$ 74,580.44
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 74,580.44	\$ 74,580.44

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,898

B. General Construction Type: Exterior BRICKFrameNumber of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		1976	\$ 100,000	1
2					2
3	TOTALS			\$ 100,000	3

Facility Name & ID Number WEST CHICAGO TERRACE

0022871

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1973	\$ 1,233,000	\$	25	\$	\$	\$ 1,233,000	4
5											5
6											6
7											7
8						903		903			8
	Improvement Type**										
9	BUILDING IMPROVEMENT			1983	34,112					34,112	9
10	BUILDING IMPROVEMENT			1987	17,555	557	20	557		8,984	10
11	BUILDING IMPROVEMENT			1988	51,503	1,635	31.5	1,635		26,092	11
12	BUILDING IMPROVEMENT			1990	4,140	131	31.5	131		1,730	12
13	BUILDING IMPROVEMENT			1992	23,333	741	31.5	741		8,354	13
14	BUILDING IMPROVEMENT			1993	22,204	610	31.5	610		6,465	14
15	BUILDING IMPROVEMENT			1994	74,985	1,923	39	1,923		18,819	15
16	TILE			1996	2,547	65	39	65		507	16
17	ROOFTOP COMPRESSOR			1998	1,653	42	39	42		229	17
18	FIRE BACKFLOW DEVICE			1998	7,245	186	39	186		938	18
19	DOORS			1999	2,734	70	39	70		336	19
20	SIGNS			1999	968	65	15	65		292	20
21	ELECTRICAL WORK			1999	8,138	209	39	209		967	21
22	CARPET, TILE, COVE BASE			2000	20,242	2,528	20	1,013	(1,515)	3,545	22
23	CUBICLE CURTAINS, DRAPES			2000	12,817	1,601	20	641	(960)	2,243	23
24	ROOF			2000	9,850	358	27.5	358		1,238	24
25	ASBESTOS ABATEMENT			2000	4,193	152	27.5	152		564	25
26	PAVING			2001	4,855	324	15	162	(162)	486	26
27	VINYL TILE			2001	4,165	728	20	208	(520)	624	27
28	FLOORING/CARPET			2002	8,200	2,181	20	410	(1,771)	820	28
29	CONDENSING UNIT			2003	1,564	26	27.5	26		26	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,550,003	\$ 15,035		\$ 10,107	\$ (4,928)	\$ 1,350,371	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$149,470	\$8,750	\$14,945	\$6,195	10	\$110,241	71
72	Current Year Purchases	5,662	2,492	283	(2,209)	10	283	72
73	Fully Depreciated Assets	316,842					316,842	73
74	RELATED PARTY		181	181				74
75	TOTALS	\$471,974	\$11,423	\$15,409	\$3,986		\$427,366	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,121,977	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$26,458	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$25,516	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(942)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,777,737	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 10,411
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT/ACTIVITY	99 FORD VAN	\$ 499.00	\$ 5,988	17
18				10,125	18
19					19
20					20
21	TOTAL		\$ 499.00	\$ 16,113	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	\$
13.	/2005	\$
14.	/2006	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 434,030	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	529,409		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,871		6
7	Other Prepaid Expenses	37,706		7
8	Accounts Receivable (owners or related parties)	465,640		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,534,656	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	317,003		15
16	Equipment, at Historical Cost	471,975		16
17	Accumulated Depreciation (book methods)	(1,828,399)		17
18	Deferred Charges	28,871		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 322,450	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,857,106	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 74,074	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,750		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,429		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,300		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 224,553	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	987,159		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 987,159	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,211,712	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 645,394	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,857,106	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 545,482	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 545,482	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	460,822	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(360,910)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 99,912	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 645,394	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,557,805	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,557,805	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	175	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 175	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,557,980	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	698,962	31
32	Health Care	1,154,132	32
33	General Administration	993,296	33
	B. Capital Expense		
34	Ownership	177,934	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,090,024	40
41	Income before Income Taxes (line 30 minus line 40)**	467,956	41
42	Income Taxes	(7,134)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 460,822	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO

If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	376	449	\$ 15,948	\$ 35.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,395	6,743	168,494	24.99	3
4	Licensed Practical Nurses	8,533	8,954	167,613	18.72	4
5	Nurse Aides & Orderlies	47,345	50,180	506,465	10.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,271	3,416	30,103	8.81	8
9	Activity Director					9
10	Activity Assistants	7,621	7,825	63,519	8.12	10
11	Social Service Workers	1,637	1,770	19,591	11.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,446	15,323	133,854	8.74	15
16	Dishwashers					16
17	Maintenance Workers	6,484	6,496	91,985	14.16	17
18	Housekeepers	11,626	12,293	84,438	6.87	18
19	Laundry	5,809	6,037	41,650	6.90	19
20	Administrator	3,813	3,894	121,839	31.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,048	8,479	65,649	7.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,687	2,753	16,528	6.00	31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	7,424	7,493	114,783	15.32	33
34	TOTAL (lines 1 - 33)	135,515	142,105	\$ 1,642,459 *	\$ 11.56	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 6,345	1-3	35
36	Medical Director	O	4,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,932	10-3	39
40	Physical Therapy Consultant	L	2,050	10a-3	40
41	Occupational Therapy Consultant	Y	656	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,571	11-3	44
45	Social Service Consultant	E	1,929	12-3	45
46	Other(specify) DENTAL CONSULT	S	3,300	10-3	46
47	REHABILITATION CONSULTANT		1,929	10a-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 26,712		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING	2000	\$ 2,787	3	\$ 464	\$ 929	\$ 929	\$ 465	\$	\$	\$	\$	\$
2	PAINTING/DECORATING	2003	4,134	3				689	1,378	1,378	689		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 6,921		\$ 464	\$ 929	\$ 929	\$ 1,154	\$ 1,378	\$ 1,378	\$ 689	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM \$3,998
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,161 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees